MEDICARE PAYMENT ADVISORY COMMISSION

PUBLIC MEETING

Ronald Reagan Building
International Trade Center
Horizon Ballroom
1300 13th Street, N.W.
Washington, D.C.

Thursday, October 28, 2004
9:32 a.m.

COMMISSIONERS PRESENT:

GLENN M. HACKBARTH, Chair
ROBERT D. REISCHAUER, Ph.D., Vice Chair
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MARY K. WAKEFIELD, Ph.D.
NICHOLAS J. WOLTER, M.D.

AGENDA ITEM:

Private plan strategies for managing the use of imaging services -- Ariel Winter

MR. WINTER: Good morning. I'll be talking about our research on strategies used by private plans to manage the volume and quality of imaging services. This work arose out of a chapter of the June 2004 report in which we explored tools used by private plans to improve the quality and reduce the cost of health care services. In that chapter we discussed ways in which plans are trying to control the use of imaging procedures while ensuring access to appropriate care. Since the June report, we've talked to several plans to gather additional information about these strategies and to find out how effective they have been.

There are a couple of reasons why we've pursued this issue. One is our general interest in helping Medicare become a more prudent purchaser. Another is that we're seeking options for reducing growth of services paid under the physician fee schedule without reducing access to care. Today, we'll summarize what we learned from our interviews with plans and highlight similar approaches in Medicare where they exist. Our goal for the March report is to recommend ways for Medicare to better control growth in imaging services while improving their safety and quality.

Before we get to the private plan approaches, I'd like to start off by reviewing trends in the use of imaging services by beneficiaries.

On a per capita basis, imaging services paid under the physician fee schedule have grown by an average of 9 percent per year between 1999 and 2002. This compares with 3 percent average annual growth for all fee schedule services.

The fastest growing imaging procedures were MRI, nuclear medicine and CT. Total spending for imaging services paid under the physician fee schedule was $6.5 billion in 2000 or 14 percent of total fee schedule spending. Radiologists accounted for about half of imaging spending and cardiologists for about one quarter.

Independent diagnostic testing facilities or IDTFs accounted for 7 percent of imaging spending but payments to these facilities doubled between 2000 and 2002. IDTFs are facilities that are independent of a hospital or physician office would provide diagnostic tests under physician supervision. They're paid fee schedule rates and are subject to special rules set by Medicare which we will touch on later.

The findings I'm going to present are based on the following sources. We interviewed medical directors and other staff at eight private plans and two radiology benefit managers, which are companies that contract with plans to provide radiology services to enrollees. We also spoke with organizations that develop accreditation programs for imaging providers such as the American

College of Radiology.

Finally, we reviewed literature on programs used by insurers to manage imaging services. However, we did not find many of these studies.

The plans are generally seeking to address similar issues. They are concerned about the proliferation of imaging equipment among ambulatory providers, which they see as stimulating demand. They note an increase in the use of imaging services by physicians who place equipment in their offices, particularly non-radiologists. There is a concern that many of the non-radiologists ordering or performing studies aren't familiar with the clinical guidelines for when a particular test is appropriate. The plans also want to protect their enrollees from unsafe or low-quality providers. And finally, they are seeking ways to counter rising consumer demand, driven in part by direct to consumer advertising.

Here is a list of the main strategies that plans are using to address these issues. Most plans have implemented at least a few of these policies. Some plans have been relatively aggressive in their choice of strategies. Others have been less so. We will summarize each strategy and focus on how effective it has been.

Plans were often unable to quantify reductions in volume or spending related to individual approaches. In many cases, multiple programs were implemented at the same time. Although we're still analyzing how feasible it would be for Medicare to adopt any of these approaches, we'll mention parallel policies in Medicare where they exist.

Several insurers said that they require outpatient imaging providers in their networks to meet basic safety and quality standards. These relate to the quality of the equipment used and the images they produce, the qualifications of technicians performing the tests, and the physicians who interpret the images and patient safety procedures including monitoring of radiation exposure.

Plans may develop their own criteria or require providers to become accredited by private organizations. Providers that fail to meet the standards are dropped from the network.

The goals of this policy are to ensure basic level of safety for enrollees, to reduce the need for repeat tests caused by low-quality images, and to weed out unqualified providers.

In terms of effectiveness, one plan that implemented standards did not experience reduced volume. On the other hand, a radiology benefit manager claimed that its programs achieved savings of about 5 percent. According to two studies, plans that combined facilities standards with physician privileging were also able to reduce spending.

Currently the government sets standards for some types of imaging facilities. However, these standards are sometimes not comprehensive or well enforced. Although CMS does not regulate imaging services provided in physician offices, it has set minimum standards for independent diagnostic testing facilities.

These these relate to the qualifications of non-physician staff, the equipment and supervising physicians.

However. CMS does not review the quality of the images produced in these facilities or their safety protocols. It also appears that the standards are not vigorously enforced. For example, each facility is subject to an initial site visit but there are usually no follow-up visits.

Another Medicare example is that many carriers are providing that providers of vascular ultrasound either be accredited or use credentialed technicians. Outside of Medicare, the FDA regulates mammography facilities. It sets standards for the equipment, technicians and the physicians who interpret the images and it also conducts annual inspections of each facility.

The Nuclear Regulatory Commission licenses nuclear medicine facilities. However, there are no federal requirements for MRI or CT imaging that would apply across all settings.

I will move on now to the next private-sector strategy which is physician privileging. In privileging, plans limit the payment for performing and interpreting certain procedures to qualified specialties. In most cases, privileging programs permit or restrict payment to an entire physician specialty based on the training a specialty receives in residency programs. In some cases, privileges are linked to individual physicians based on their training and credentialing. Privileging, we noted, is often combined with facilities standards.

In the more restrictive version of privileging, radiologists are allowed to provide most services consistent with their training. Other specialties are more restricted, however. For example, cardiologists would only be permitted to provide nuclear cardiology and cardiac ultrasounds. Some programs we heard about are less restrictive and , only place limits on primary care providers and podiatrists.

The goals of privileging are to prevent poor quality studies that lead to inaccurate diagnoses or repeat tests. Plans report that there's often significant opposition to privileging, at least initially. Plans also told us that this approach leads to modest savings due to fewer overall tests. And they also noted that privileging is less expensive to administer that other strategies.

Currently in Medicare, physicians are paid for medically necessary services provided within the scope of practice for the state in which they are licensed. In other words, Medicare generally does not restrict what services physicians can bill for as long as they are medically necessary. However, there are a few exceptions. CMS recently decided to cover PET scans to diagnose Alzheimer's disease in certain patients with mild cognitive impairment. However, these tests can only be interpreted by physicians in certain specialties with expertise in reading these scans.

Another example, Medicare only covers power operated vehicles or scooters if they are ordered by certain specialties such as physical medicine or orthopedic surgery. And

finally, chiropractors can only be paid for one type of service and are not allowed to bill for any imaging studies.

The next private plan strategy consists of programs to increase compliance with clinical guidelines for the appropriate use of imaging services. The least restrictive of these approaches is educating physicians about the appropriate use of imaging. An example of this would be offering online clinical education.

Another approach is to profile the physicians' use of imaging services. In profiling, plans compare physicians' use to peer benchmarks and identify physicians who account for a high amount of imaging spending. Plans then educate these physicians about the appropriate use of imaging.

There is an example of profiling in Medicare. Medicare's quality improvement organizations sometime engage in physician profiling to improve the quality of care for some conditions. They analyze variations in physicians practice patterns and provide them with feedback. The next presentation will focus specifically on profiling issues.

The most restrictive of these three approaches is preauthorization. Most plans we interviewed require it for PET scans while a few also require it for MRI and CT studies. Two of the plans that require preauthorization experienced initial savings due to denials of requests. However, the denial rates declined over time as physicians learned the criteria for approval. Other plans claimed that preauthorization is ineffective at reducing volume and that it is expensive to administer.

We learned about a couple of variations on preauthorization. One plan requires physicians to notify it when they plan to order certain studies. The plan suggests alternatives if another test is more appropriate but does not deny payment. Some plans require physicians to consult with radiologists before ordering studies. And in some cases, the radiologist is responsible for approving the order.

We are not aware of any preauthorization programs and Medicare.

Many private plans using coding edits for imaging services. One type of edit detects improper billing codes such as unbundling of services. Another type of edit adjusts the payment for multiple procedures done on contiguous body parts. An example would be CT of the abdomen and CT of the pelvis. The first procedure is paid at its full rate while the second procedure is paid at half its normal rate. The premise is that the second procedure takes less time than if it were performed separately because the patient has already been prepared for the procedure and the machine is already set up and running. Usually only the technical component fee, which covers the cost of the equipment and the technician's time is adjusted.

Plans emphasize that coding edits should be communicated to physicians so they can bill correctly. A company that develops coding edits for imaging estimates that they reduce spending by

about 5 percent.

Medicare has developed a system of coding edits for all services called the Correct Coding Initiative. These edits detect improper billing such as unbundling, and claims that include mutually exclusive services. Medicare does pay a discounted rate for multiple surgical procedures provided in the same encounter. However, there is no similar policy for multiple imaging procedures.

It is worth noting that 40 percent of Medicare claims for CT services include two or more CT services on the same claim. CT of the abdomen and the pelvis are billed together most frequently. When this occurs, Medicare pays the full rate for both services.

Now we'll turn to the remaining two private sector strategies. Some plans have created two tiers of imaging providers, preferred and non-preferred. Providers in the preferred tier are willing to accept lower plan payments in exchange for higher patient volume. In some cases, they must also meet quality standards.

One plan charges its enrollees lower copayments when they use a preferred facility. Current law makes it difficult for traditional Medicare to create tiered networks. For example, current law does not permit Medicare to vary beneficiary cost-sharing by provider.

Finally, several private plans attempt to educate patients about the risks, benefits and appropriate use of imaging procedures. These efforts are meant to counter demand stimulated by direct to consumer advertising. Medicare has developed several beneficiary education programs in areas such as vaccination, cancer screening and disease management but we're not aware of any education specifically related to imaging.

However, the NIH has developed web-based consumer information on various imaging modalities. Perhaps Medicare could target this information to beneficiaries.

For our next steps, we plan to analyze how feasible it would be for Medicare to implement any of these approaches. Part of this includes interviewing Medicare carrier and CMS staff to get their feedback on what the legal data and administrative barriers might be. We will also further explore current efforts by Medicare to manage imaging services.

We would like to get your feedback on the strategies presented today, which will help us develop draft recommendations for you to consider. This concludes my presentation and I look forward to your questions.

MS. DePARLE: In the presentation that we had in -- I think it was either May or March, sometime in the spring anyway, about this subject, there were two things that struck me about it. One issue was self-referral, the extent to which the medical officer from the Blue Cross Plan of Michigan and the administrator from the Tufts New England Health Plan both talked about that as being a problem. You listed that on here as one of the things that private plans are trying to address.

So I'm curious, which of the strategies that you discuss here do you think would most effectively deal with that problem of self referral? And have you been able to determine the extent to which that is a big part of the issue in Medicare, the growth of imaging spending that we would consider to be inappropriate? Which strategy would be the most effective in dealing with that? Or would it take a change in the law?

MR. WINTER: To some extent, facility accreditation might deal with that. If physicians are doing imaging in their own offices, they may not want to invest in the steps necessary to come up to accreditation standards. But probably privileging is the most effective way to target this because you're targeting primarily non-radiologists, who are the ones ordering the test. So if you prevent them from billing for performing and interpreting the studies, there's less of an incentive for them to buy equipment and install it in their offices.

You could also look at tiering of providers as a way to do that, if you create a preferred tier that excludes physicians who are ordering the tests and also performing them. You could limit the providers in the preferred tier.

In terms of your second question about to what extent this influences growth of imaging in Medicare, we really don't know. I could actually show you this slide here, which shows you the distribution of imaging spending under the physician fee schedule by specialty. So to some extent, cardiology may be an area where they are actually performing the studies on equipment in their offices. But it could be they are interpreting studies that are done in the hospital. It's hard to tell from this. We have to look at the data in a finer way to get at that.

DR. MILLER: I think the third part of the question -- I agree about the strategies that would be most likely to get at it. I think all of them in Medicare would involve a change in law.

MR. MULLER: Thanks for bringing up this slide because my question is along these lines.

In terms, of what do we know about the cost effectiveness of using things like privileging and authorization and so forth to try to direct imaging towards a limited set of people; e.g., radiologists, cardiologists, versus letting it be more open to all specialties? And especially given that we know that with the -- again, we studied last spring and before that, that imaging equipment technology is getting cheaper -- I shouldn't say cheaper, less expensive -- and probably more miniaturized and more efficient and faster, et cetera and so forth. I would at least hypothesize or surmise that there would be a greater tendency to spread this to all doctors, as opposed to just radiologists and cardiologists and so forth.

So if I'm correct in saying the trend will be to spread this out to all physicians, maybe not chiropractors but all physicians, do we think it's more cost-effective based on what we know from the private plans and so forth to try to limit this to several and use credentialing and authorization and so forth as a

way of limiting? Or is it, in a sense, cheaper to let internists and others do it who may have a lower fee schedule on this compared to radiologists and so forth?

MR. WINTER: The rate of pay would be the same regardless of who's actually performing or interpreting the test. So the internist would get paid the same as a radiologist. That wouldn't vary.

MR. MULLER: For example, if an internist reads a CT -- I mean, by and large, at this moment they don't, they let radiologist do it. But if an internist read a CT, he or she would get the same fee as a radiologist?

MR. WINTER: That's right.

MR. MULLER: So in terms of whether we are better off trying to limit this in terms of cost effectiveness? Do we have any evidence on that? Trying to limit it to a smaller number rather than a larger?

MS. DePARLE: It's also quality. I said I had two points and that was the other thing I was going to say based on that panel, is which of these two things goes to the quality, as well?

MR. WINTER: They all attempt to address quality. The facility standards are training at the quality of the facility and the equipment and the technicians, primarily. And privileging is trying to get at the quality, the qualifications of the physician who is supervising and interpreting the results, sold, supervising the tests and interpreting the results. So they're sort of getting at different parts of the quality question.

Coding edits is more related to paying appropriately. And the physician education, beneficiary education is also trying to drive quality.

MR. SMITH: Thank you, Ariel. As I read the material, my reaction to what recommendations we ought to make was essentially all of the above. That for both quality and management reasons there is some reason to think that each of these strategies has some value. None have particularly great downsides and we ought to authorize CMS to employ all of them.

One question, Ariel. You mentioned that CMS doesn't have the authority to manipulate copays in a way that would allow it to create tiered networks. It could effectively manipulate copays though, by creating tiered networks with a lower fee schedule, couldn't it?

Without a change in the law, Medicare couldn't create a preferred network of providers who are willing to accept a lower fee and, in effect, create a lower copay?

DR. MILLER: Not in traditional fee-for-service. You can do that within a plan but not --

MR. SMITH: We might want to think about asking Congress to allow Medicare to do that.

DR. CROSSON: I'm going to structure my comments using the barn analogy. I'll try to do that all day. So I'll talk about the front door and the back door of the barn, using Bob's barn

analogy from before.

And again, admitting some difficulty necessarily extrapolating from the model I am in and have been in for a long time, the prepaid group practice model, is a different model. And so some of the tools that we, I think, have used effectively don't necessarily apply in fee-for-service and in small solo group practice models.

Nevertheless, I would have to say I think my sense of this is that the preauthorization model is probably not going to be terribly effective. It certainly hasn't proven to be. We use a little bit of that, in terms of radiology consultation, which works in our setting.

But I think the experience of the '90s is that the preauthorization approach, in general, is not terribly effective. It's very difficult to do, very difficult to second guess the judgment of the physicians and the like.

I would, in this case, much more favor the back door. That has to do with the issue of combining profiling with educational efforts. And even if you don't move toward some particular authority or plan on the part of CMS to intervene on the basis of the profiling, the profiling itself is effective for two reasons.

Number one, it often can genuinely be an educational tool for the physicians, particularly physicians practicing in isolation tend to not always understand how their patterns of decisionmaking differ from the rest of the physician community, particularly outside the geography where they are. And so sometimes, physicians are genuinely shocked to find that a pattern of decisionmaking that they have and believe honestly is correct, turns out to be quite different from the standard of the physician community.

Secondly, I think physicians are competitive people. They are, for the most part, individuals who have spent their life trying to get A's on report cards, which is not necessarily a bad thing. I don't think most of us would like to have a physician who is satisfied getting C's. But I do think that physicians are competitive, and in that environment will often pay attention to something that looks like it shows that they, again inadvertently perhaps, deviate from the norm. And we tend to see, in that environment, some reversion to what hopefully is an appropriate mean.

So we're going to have another discussion about profiling but I would suggest maybe that we focus in that direction.

DR. REISCHAUER: Jay, you went to a school where everybody got A's?

DR. CROSSON: Everybody was trying to get A's.

DR. MILSTEIN: A couple of comments.

First, to the degree there is any evidence on the question of whether or not this increasing volume of radiology services is improving health or holding health constant, is improving the overall cost efficiency of Medicare spending, would be an interesting question. We're doing the study because we perceive

this to potentially be a problem and so it would be nice to have some evidence pro or con, if there is any, on whether it's a problem.

I suspect if Elliott Fisher and Jack Wennberg were here, they would say they already have evidence to suggest that the prior volume was not very cost efficient and therefore it's unlikely that this new increase in volume is likely to be delivering a lot of value. But it's an empirical question and it would be nice to have some information about that.

I categorize the problems in three buckets. First of all, we have what I'll call zero-value studies. Studies that are done to the population where there is, as far as we can tell, no health benefit. Secondly, problems in the actual quality imaging themselves so that they're not applied or interpreted correctly. And third is, I'll call it non-competitive unit prices where the unit price you're paying does not reflect the most competitive pricing you can get if there was price competition.

If you think about these three problems and say what are the intervention options that match up with these three problems, I think on the first problem, which is the ordering of imaging studies for which there is no likely health value, there it seems to me the unit of profiling is not the imaging center or the radiologist but the referring physician.

I think if I were to focus on Jay's recommendation, the profiling with respect to quality and utilization should be for the referring physician not the imaging center or the radiologist.

And then the second two problems, that is the poor administration of the imaging study or the incorrect interpretation of it or non-competitive price. For that the unit of intervention and then potentially profiling would also lend itself. It would also be a little bit more tricky, but you could also profile those two past performance. There the unit of profiling, with or without economic reinforcement, would be the radiologist or the imaging center.

So I think there's some opportunities to essentially make some more specific our recommendation geared to the two different problems. Problem A is referring physicians, inappropriately referring -- sometimes to themselves -- radiology studies. And secondly, the center or professional receiving the request.

DR. WOLTER: I just would emphasize Arnie's point on unit pricing. At least in our experience, imaging is one of those few service areas where there is really a very large bottom line. And I think that that is maybe the major driver of at least the expansion of capacity. I think there's other reasons why volume also goes up.

I hesitate to emphasize that because for some of use, we use those dollars to subsidize other services. But almost certainly, the ROI you can drive out of imaging services really is a major driver of what is going on. So we should at least maybe mention that in our study.

DR. BERTKO: I just have a quick follow-up to both Jay and

Arnie's comment, that profiling physicians with imaging seems to me to offer a great opportunity to do two things. One, within the community, but also across the nation, because everybody recognizes it's quite different and just the education component of this might be a very helpful and straightforward way to reduce costs in the future.

MR. HACKBARTH: Anyone else? Ariel, do you have any questions that you need clarified?

MR. WINTER: This is very helpful guidance and I really appreciate it.

There was one thought that occurred to me that I wanted to add to my answer to Nancy-Ann's question about self-referral which is that studies by the GAO and other groups in the late '80s, early '90s, found that physicians who have a financial interest in an imaging center or the equipment in their offices, order many more tests than other physicians for their patients. So there's evidence of increased volume associated with self-referral. So that could be something that's driving this increase.

MR. HACKBARTH: Thank you.

Next on the agenda is the related topic, somewhat related topic, of profiling.